Editorials and Association Notes

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Editor
F. G. ALLISON, B.A., M.D. (Man.), M.R.C.P. (Lond.)

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Work and Amusement for the Bedridden

In the case of patients who are willing to accept advice, the doctor can make a long period of bed rest more bearable by suggesting suitable mental work and amusement.

Patients who already have a trade or profession can plan a course of technical reading in their chosen fields. Those too young to have an occupation can carry on with school work or take a correspondence course. For example, all patients entering the Manitoba Sanatorium are offered correspondence courses in Automobile Operation and Repair, Advertising, Commercial Art, Cookery, Dressmaking, Refrigeration, Photography, Printing, Radio Servicing, Bookkeeping, Shorthand, Typewriting, etc., etc. The technical branch of the Manitoba Department of Education arranges for these courses and pays half the cost.

Pastimes such as fancy work, letter-writing, crossword puzzles and games will occupy some time, but the main amusements for the bedridden are reading and the radio. The best way to listen to the radio is to make a list of desired programs from the newspaper each day and to set a little alarm clock to ring just when the wanted program is due.

Reading should be divided into light amusement and serious books. Too much of either causes a weariness of the spirit. According to the patient's taste the light material will consist of fiction magazines, detective stories, wild west stories, love stories, humorous stories or novels. If an adequate library is not available cheap paper-covered books such as the Penguin volumes may be purchased. Most of the first hundred titles issued in this series are worth reading. Serious books comprise biography, history and travel. A few suggested titles are Maurois' "Disraeli," Macaulay's "History of England," volume one, Prescott's "Conquest of Peru" and "Conquest of Mexico," and Horn's "Trader Horn."

OBITUARY

Dr. Stanley G. Herbert

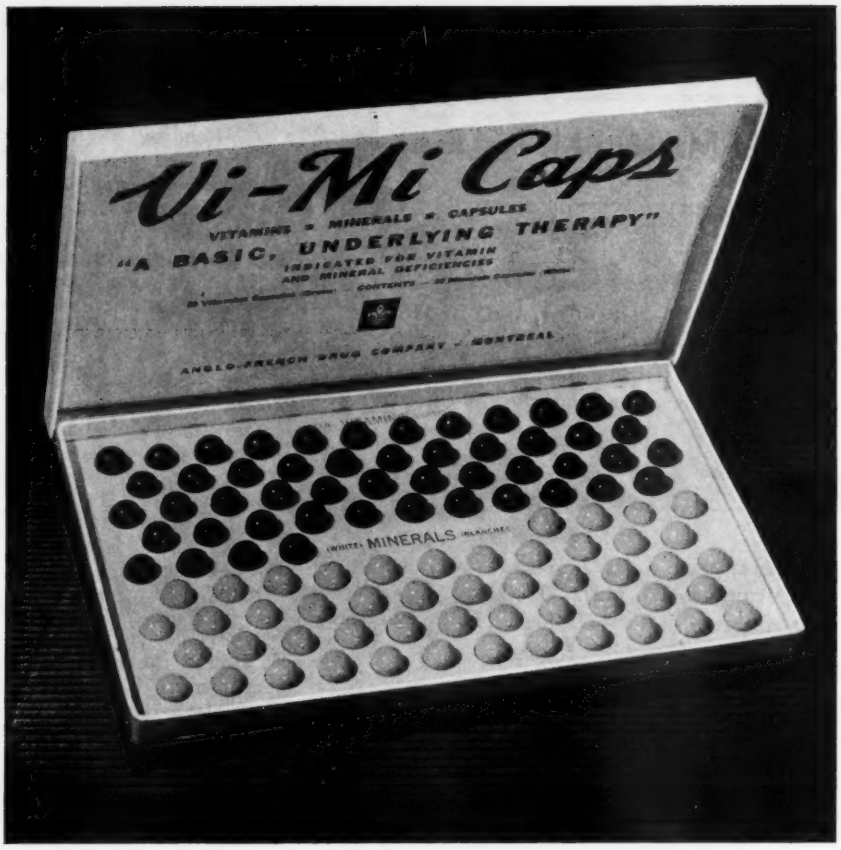
No event in recent years has more deeply stirred the medical profession in Winnipeg than the tragic death on September 28th of Dr. Stanley G. Herbert. He and his wife had driven over about midnight to see his mother who had been reported to be ill at her home on Cornish street near Misericordia hospital. As the following day was Sunday no undue alarm was felt over his absence from home until about seven in the evening when it was discovered that the doctor, his father, mother and nephew were dead, and his wife unconscious from gas poisoning. Mrs. Herbert was removed to Misericordia Hospital, but despite unremitting care, she died three days later. A joint funeral of the five victims was held from Westminster Church on October 2nd. At a coroner's inquest it was established that gas seeping from a broken main had been responsible for the tragedy.

At the time of death, Dr. Herbert, at the age of 47, was treasurer of the Manitoba Division of the Canadian Medical Association, member of the surgical staff of St. Boniface Hospital, and a recently created Fellow of the American College of Surgeons. He had been Chief of Staff of St. Boniface Hospital for two years and treasurer of the Winnipeg Medical Society. After graduating from the Faculty of Medicine, University of Manitoba in 1919 he practised in Winnipeg first with the late Dr. Gerhard Hiebert, and then with Dr. Dan. Hossack.

In his youth he was an excellent hockey player with the Varsity team and with the Senior Winnipegs in 1913 and 1914. Later he was keenly interested in golf and curling, despite the demands of a heavy practice.

His bright personality, his kindness and his professional ability made him a general favorite and his loss is widely mourned.

He is survived by four daughters, to whom our deepest sympathy is extended.



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Personal Notes and Social News

Conducted by Gerda Fremming, M.D.

Captain John M. Kilgour, R.C.A.M.C., and Mrs. Kilgour are receiving congratulations on the birth of a daughter. Mrs. Kilgour was formerly Miss Betty Joyce.

♡ ♡ ♡

Dr. Robert F. M. Myers, R.C.A.M.C., and Miss Joan Margaret Elliott, daughter of Dr. and Mrs. W. J. Elliott of Brandon, were married on September 27th in St. Paul's United church, Brandon. Dr. and Mrs. Myers left by motor for the East and will reside in Ottawa.

♡ ♡ ♡

Dr. and Mrs. William Ormond have left for Nelson, B.C., where they will make their home.

♡ ♡ ♡

Mr. and Mrs. Hugh Neave, Higher Disley, Cheshire, England, are receiving congratulations on the birth of a daughter, October 4th. Mrs. Neave was Dr. Shirley Taylor, '35.

♡ ♡ ♡

Dr. D. G. Revell has joined His Majesty's Forces.

♡ ♡ ♡

Dr. Joseph S. Holowinski was recently married to Miss Helene Rosemary Julius. The honeymoon is being spent in Eastern Canada.

♡ ♡ ♡

Dr. and Mrs. Brock Fahrni are enjoying a short leave in Vancouver. Dr. Fahrni is with His Majesty's Forces.

♡ ♡ ♡

Dr. and Mrs. Daniel Blake have arrived in Winnipeg from Philadelphia where they have been living for three years. They will only be in the city a short time. Dr. Blake is the son of the late Dr. M. R. Blake.

♡ ♡ ♡

Dr. Margaret Anderson (Greta Connor '38) of Regina, spent a two weeks' vacation in Winnipeg, the guest of her parents.

♡ ♡ ♡

The Association wishes to extend its deepest sympathy to Dr. and Mrs. W. W. Musgrove and family in the loss of their son, Roy, who was accidentally killed on Tuesday, October 14th, when he fell down a stope in the Hudson Bay Mining and Smelting Co. mine at Flin Flon, and also to Dr. James M. Morrow of Prince Albert, Sask., in the loss of his wife on Oct. 18th.

♡ ♡ ♡

Lieut. Fred Walton, R.C.A.M.C., and Mrs. Walton have arrived recently from England and are the guests of Dr. Walton's parents, Dr. and Mrs. F. C. A. Walton.

Major George Ryan, who has been overseas with the 5th Canadian General Hospital spent a short leave in Winnipeg.

♡ ♡ ♡

Dr. and Mrs. Harold Hutchison of Bridgetown, Barbados, B.W.I., have arrived in Winnipeg. Dr. Hutchison is the son of Dr. J. N. Hutchison of Winnipeg.

♡ ♡ ♡

Dr. John C. Rennie, son of Mrs. Rennie and the late Dr. W. H. Rennie, of Portage la Prairie, was married on October 10 in Portage to Miss Margaret Isobel Souter, daughter of Mr. and Mrs. George Souter. Dr. and Mrs. Rennie left on a wedding trip to the Pacific Coast.

♡ ♡ ♡

Dr. George Wallace Elliott, aged 77, retired Canadian Government Immigration physician and early settler in Manitoba, died at his home on Lulu Island, near Vancouver, on October 22. He was born in Ireland, and first settled in Manitoba as a farmer. Later, he joined the Winnipeg police force, where he served for seven years until he graduated from Manitoba Medical College in 1897. He went to the Yukon in the Gold Rush of 1898 and practiced in the north until 1903, when he was made Canadian Government Immigration Medical Inspector. He went first to Ellis Island and later to Portland, Me. He retired in 1925.

♡ ♡ ♡

The *Review* is always glad to receive items of a personal or social nature for this page; however, as the *Review* goes to press a week in advance of publication date, contributions must be in by the 20th of the month preceding date of issue.

Winnipeg Authors

In the London *Lancet* of August 23 there appeared an article by Lt. Col. C. H. A. Walton, M.D., Majors H. M. Graham, M.D., and L. P. Lansdown, M.D. Lt. Col. Walton and Major Lansdown are Winnipegers on the staff of No. 5 Canadian General Hospital, Taplow, England. The article described three cases of acute ulcerative stomatitis characterized by severe toxæmia and extreme prostration. The organism found in all three was a Gram positive encapsulated diplococcus, morphologically identical with the pneumococcus but with cultural differences.

The patients did not respond to adequate sulphapyridine therapy, but transfusions of pooled whole blood seemed to act as a specific. It is suggested by the authors that infections of the mouth with organisms other than Vincent's may be associated with a deficiency in nicotinic acid.

Department of Health and Public Welfare

We are publishing herewith the fourth of the essays prepared by the medical students before taking the final examination in Preventive Medicine at the Faculty of Medicine of the University of Manitoba last year. The one for this month is written by Doctor N. L. Auckland, on the subject "A Provincial Venereal Disease Programme," and reads as follows:

"A Provincial Venereal Disease Programme"

"It is my plan in this article to outline, as briefly and clearly as possible, the organization, methods and problems of a Provincial programme of Venereal Disease Control. In doing so, I propose to deal with the subject matter under the following headings:—

"(1) General Aspects of the Problem

"(2) Legislation

"(3) Organization

"(4) The Private Practitioner and Venereal Disease Control.

General Aspects

"The Venereal Diseases constitute one of the major public health problems of today. In Canada, treatment of this problem is, as yet, in its infancy. The scanty reliable statistical data which is available, has not shown any clearly defined diminishing trend. Indeed, available figures would suggest an incidence considerably above that of Great Britain and the Scandinavian countries where exceptional results have been obtained in control programmes. It is not difficult to understand why venereal disease still constitutes such a major health problem when one considers how complex are the factors relating to acquisition and transmission—how rooted it is in defects and inadequacies of our Social and Economic Life and what barriers are raised by prudery, ignorance and defeatism on the part of the public.

"Because of these intensely human elements, the Venereal Diseases stand alone among the infectious diseases, and special considerations must be made in dealing with them. Thus, besides an adequate programme for prophylaxis, diagnosis and treatment, it is important to think of social reform and social hygiene. No Venereal Disease programme is complete unless there is a close co-operation between the medical and social units of a community.

Legislation

"Without comprehensive legislation the hands of the Public Health Department are tied. It is suggested that the following points be dealt with:

"(1) Definition of Venereal Disease.

"(2) Compulsory examination and treatment of prisoners.

"(3) Medical health officers be given authority to require any suspected person to be examined by a qualified physician.

"(4) Suppression of quacks, treatment by the unqualified and advertisement of articles for treatment or prevention.

"(5) Prosecution of any infective person who does any act liable to spread the infection.

"(6) Protection of patients under treatment, i.e., reports, names, etc., are confidential and not open to the public.

"(7) Pre-marital and pre-natal examinations.

"(8) Free silver nitrate to hospitals for control of gonorrheal ophthalmia.

"(9) Suppression of prostitution—this is a very important problem. Fundamental to the effective control of any communicable disease are the measures directed toward finding the source of the infection and making it as inaccessible as possible. Commercialized prostitution is probably the most prolific source of venereal infections and laws to stamp it out must be definite and adequate. Having these laws, it then should be the aim in every Venereal Disease programme, to induce a most vigorous enforcement of them. It has been shown here in Vancouver that the effective enforcement of the sections of the Criminal Code directed against commercialized prostitution has reduced the incidence of venereal disease in the male population of the City. (1).

"(10) Free treatment of all patients with venereal disease. (See below).

"These are by no means all that should be dealt with, but would form a basis for any progressive venereal disease programme.

Organization

"Under the Provincial Department of Health there is usually a sub-department, such as a Department of Disease Prevention, which includes venereal disease.

"The working unit of this is the 'Government Clinic' which is really the source of the active campaign. This clinic is free. Grants to the Provinces by the Dominion Government commenced in 1920 and now free treatment is in effect in every Province in Canada.

"In providing free treatment, the object is two-fold:

"(a) Cure of existing cases and

"(b) Prevention of new ones.

"It is generally felt that the sooner cases are brought under treatment, the fewer fresh cases will arise. Treatment, therefore, is available to all classes, the aims of the clinic being:

"1. To treat promptly and effectively all persons with venereal disease.

"2. To place a specialist within reach of all.

"3. To make continued treatment and ultimate cure (in the majority of cases) possible.

"4. To reach the greatest number possible as early as possible.

"5. To disseminate information concerning nature and prevalence of venereal disease.

The organization of the clinic itself may be as follows:

"Director:—A qualified physician and a specialist in Venereal Diseases. He should be chosen not only for his knowledge, but for his enthusiasm and ability. Upon his initiative largely depends the success or failure of the clinic.

"Medical Consultants:—also qualified physicians who work at the clinic either full or part-time. They diagnose and supervise treatment of all patients.

"Technicians:—trained in methods of laboratory diagnosis and technique of treatment. In most clinics, trained orderlies or special male technicians take care of male patients and nurses or female technicians take care of female patients.

1. The Canadian Public Health Journal—October, 1940. "Commercialized Prostitution and Venereal Disease Control," Donald H. Williams, M.D. — Director, Division of Venereal Disease Control; B.C. Board of Health.

"Good laboratory facilities are essential—these include darkfield microscope, good stains for smears, and a good standard of investigation for gonorrhœa, i.e., smears and cultures, etc. Treatment as outlined by the consultant is carried out by the above technicians and records of all treatment are carefully kept.

"Beds must be available for the more severely or acutely ill. Facilities for use of malarial therapy are necessary.

"**Department of Records and Statistics**—is invaluable in any clinic. In this way the progress and success of the clinic can be watched, errors and weaknesses picked up and the whole programme strengthened and rounded out.

"**Social Service Department** is also an essential to the Venereal Disease clinic. The job of these workers is most complex and difficult. They are the ones who are usually entrusted with finding new cases, contacts, sources, etc. Here the human element comes to the fore again, so that the workers must be chosen for their special aptitude in this direction. They must be tactful as well as persistent. New cases must be persuaded to come to the clinic for treatment, and having once started, to come regularly. Recalcitrant patients must be written, re-written, interviewed and argued into returning. Compulsion should only be the last resort.

"Thus through a competent Social Service the Clinic is able to give prompt and adequate treatment to each new case as it is found, and to each contact or source as it is unearthed, and thereby materially reduce the incidence of venereal disease.

"Also through the efforts of the Social Service branch of the clinic, patients are educated as to the characteristics of these diseases, their incidence, mode of transmission, diagnosis and chance of cure. In syphilis especially, it must be emphasized in the layman's mind, that in early cases the percentage of cures is considerably higher than in late cases.

"An attempt must also be made to remove the stigma usually attached to venereal disease. This can be done mainly by public education. The methods of putting this across are many—personal contact, motion pictures, records, public talks and pamphlets.

"**Public Health Nurses** should all receive an adequate training in venereal diseases; and the best and most logical place for this is the clinic where they can study the diseases as they are diagnosed, treated and cured. Here they learn the problems that are presented by the patient and they get a better insight that will later be of great value to them in their work. No public health nurse is fully equipped to do her best work unless she knows enough about these diseases to suspect their presence when it should be suspected and knows enough to be able to steer the infected to those services the community has to offer.

"Therefore, every Venereal Disease programme should make some provision for the instruction and training of these nurses in venereal disease.

The Private Practitioner

"Last, but by no means least, we must consider the place of the private physician with regard to venereal disease control.

"Provincial action alone cannot hope to wipe out venereal disease. The patient raises barriers both natural and artificial which often no one but his own doctor can break through. However, the relatively small number of doctors cannot treat all patients with venereal disease. The answer to this is the tax-supported clinic as mentioned above. This, plus providing anti-luetic drugs free, facilities for Darkfield and serological examinations at a Provincial laboratory, and possibly courses of instruction in venereal diseases, is the duty of the state to the physician.

"On the other hand, the duty of the physician to the state must be primarily, a co-operative attitude. His care of venereal disease patients must be as good as that of the clinic, or not at all. He should be especially prompt in reporting all cases, recalcitrant patients, sources and contacts. He should instruct each patient about the disease, explaining in lay terms, complications without adequate treatment, chance for recovery, complications in marriage, etc.

"The private doctor is especially important with regard to venereal disease in pregnant women. He should do a serological test on all pre-natal cases as soon as they present themselves. Inconclusive reports should be repeated. If the results are positive, husband and family, contacts and sources should be diligently sought. Treatment should be instituted immediately, and carried through to cure. The patient should be informed as to the nature of her ailment and instructed re her infectiousness. Periodic examination of the child should be routine and treatment started on positive diagnosis.

Summary

"1. Of all infectious diseases, venereal disease presents the most complex and difficult problems.

"2. A plan for Venereal Disease Control must be adequate and effective.

"3. Laws must be all-embracing, and must be stringently enforced.

"4. Treatment must be available to all.

"5. An effort must be made to remove taboos and educate the public.

"6. A close co-operation must exist between private physician and the Provincial Health Department."

COMMUNICABLE DISEASE REPORT

August 13th - September 9th

Anterior Poliomyelitis: Total 402—Winnipeg 92, St. Boniface 26, Unorganized 19, Strathcona 12, St. Clements 11, Transcona 11, Portage la Prairie Rural 10, St. James 10, Brandon 8, Rosedale 8, Tache 8, Norfolk North 7, St. Vital 7, Ste. Anne 6, Brokenhead 5, Coldwell 5, Kildonan East 5, Morden Town 5, Turtle Mountain 5, Westbourne 5, Woodlands 5, Bifrost 4, Birtle Rural 4, Gladstone 4, Grey 4, Kildonan West 4, Lakeview 4, Rhineland 4, Rockwood 4, Rosser 4, Saskatchewan 4, Springfield 4, Stonewall 4, Victoria 4, DeSalaberry 3, Lansdowne 3, Macdonald 3, Montcalm 3, McCreary 3, Portage la Prairie City 3, Ritchot 3, Stanley 3, St. Paul East 3, Teulon 3, Assiniboia 2, Cartier 2, Elton 2, Fort Garry 2, Franklin 2, Langford 2, Morris Rural 2, Riverside 2, Selkirk Town 2, Siglunes 2, Ste. Rose Rural 2, Woodworth 2, Argyle 1, Charleswood 1, Daly 1, Dauphin Town 1, Ellice 1, Emerson 1, Gimli Village 1, Glenella 1, Hamiota Rural 1, Hanover 1, Lorne 1, Miniota 1, Ochre River 1, Pembina 1, Pilot Mound Village 1, Piney 1, St. Andrews 1, St. Laurent 1, Thompson 1, Tuxedo 1, Virden Town 1, Winnipeg Beach 1 (Late Reported: St. Laurent 1, Unorganized 3).

Encephalitis: Total 394—Winnipeg 88, Brandon 18, St. Boniface 17, Stanley 16, Transcona 9, Turtle Mountain 8, Argyle 7, Portage la Prairie Rural 7, St. James 7, Whitewater 7, Unorganized 6, Arthur 5, Cypress South 5, DeSalaberry 5, Norfolk North 5, Pipestone 5, Rhineland 5, Springfield 5, Victoria 5, Brenda 4, Cameron 4, Franklin 4, Hamiota Rural 4, Harrison 4, Lorne 4, Portage la Prairie City 4, Riverside 4, Rockwood 4, Stonewall 4, St. Vital 4, Westbourne 4, Edward 3, Grey 3, Hamiota Village 3, Neepawa 3, Oakland 3, Souris 3, Shellmouth 3, Sifton 3, Woodworth 3, Assiniboia 2, Birtle Rural 2, Cartier 2, Gladstone 2, Hanover 2, Kildonan East 2, Macdonald 2, Miniota 2, Minnedosa 2, Napinka 2, Norfolk South 2, Roblin Rural 2, Rosser 2, Siglunes 2, Strathcona 2, St. Andrews 2, Ste. Anne 2, St.

Laurent 2, St. Paul East 2, Ste. Rose Rural 2, Ste. Rose du Lac Town 2, Tache 2, Tuxedo 2, Winchester 2, Woodlands 2, Albert 1, Archie 1, Beausejour 1, Bifrost 1, Blanshard 1, Brooklands 1, Charleswood 1, Cypress North 1, Daly 1, Ellice 1, Fort Garry 1, Gilbert Plains Rural 1, Kildonan North 1, Kildonan Old 1, Kildonan West 1, Killarney Town 1, La Broquerie 1, Lakeview 1, Louise 1, Melita 1, Minto 1, Mossey River 1, Pembina 1, Pilot Mound Village 1, Piney 1, Plum Coulee 1, Ritchot 1, Rivers Town 1, Roland 1, Strathclair 1, St. Clements 1, Thompson 1, Virden Town 1, Wallace 1, Whitehead 1, Whitemouth 1 (Late Reported: Brandon 1, Gimli 1, St. Clements 1).

Tuberculosis: Total 60—Unorganized 10, Winnipeg 7, Brandon 5, Blanshard 2, Norfolk North 2, Portage la Prairie City 2, Selkirk Town 2, St. Boniface 2, Assiniboia 1, Brokenhead 1, Brooklands 1, Cartier 1, Dauphin Rural 1, Dufferin 1, Ellice 1, Flin Flon 1, Fort Garry 1, Kildonan East 1, Lac du Bonnet 1, Lakeview 1, Macdonald 1, Morris Rural 1, Mossey River 1, McCreary 1, Ritchot 1, Rosedale 1, Saskatchewan 1, Stanley 1, Ste. Anne 1, St. James 1, St. Laurent 1, The Pas 1, Transcona 1, Turtle Mountain 1, Westbourne 1, Winchester 1.

Mumps: Total 41—The Pas 9, Tuxedo 8, St. James 7, Winnipeg 5, Brandon 3, Flin Flon 1, Portage la Prairie City 1, Transcona 1 (Late Reported: Brandon 6).

Chickenpox: Total 26—Winnipeg 9, Brandon 6, Emerson 2, Selkirk Town 2, Hanover 1, Pipestone 1, Saskatchewan 1, Stonewall 1, St. Vital 1 (Late Reported: St. Boniface 2).

Measles: Total 18—Winnipeg 4, Argyle 2, Brandon 2, Hamiota Village 1, Portage la Prairie City 1, Woodlea 1, Victoria 1 (Late Reported: Brandon 5, St. Boniface 1).

Whooping Cough: Total 17—Dauphin Town 5, Rockwood 4, Unorganized 3, Winnipeg 3, Brandon 2.

Scarlet Fever: Total 15—Winnipeg 5, Kildonan East 2, Brokenhead 1, Hamiota Rural 1, Macdonald 1, Ochre River 1, Portage la Prairie Rural 1, St. Andrews 1 (Late Reported: St. Laurent 2).

Influenza: Total 13—Brandon 4, Hamiota Rural 2, Blanshard 1, Elton 1, Hamiota Village 1, Norfolk North 1, Sifton 1 (Late Reported: Unorganized 1, St. Francois Xavier 1).

Pneumonia Lobar: Total 9—Brandon 3, Sifton 1, La Broquerie 1 (Late Reported: Mossey River 1, St. James 1, Assiniboia 1, St. Boniface 1).

Diphtheria: Total 5—Winnipeg 4, Cartier 1.

Meningococcal Meningitis: Total 3—Fort Garry 2, Tuxedo 1.

Erysipelas: Total 3—Brenda 1, Winnipeg 1, Woodlands 1.

Puerpural Fever: Total 1—Lakeview 1.

Undulant Fever: Total 1—Brokenhead 1.

German Measles: Total 1—Brandon 1.

Venereal Disease: Total 127—Gonorrhœa 88, Syphilis 39.

DEATHS FROM COMMUNICABLE DISEASE
August, 1941

RURAL—Cancer 35, Lethargic Encephalitis 20, Tuberculosis 18, Pneumonia Lobar 2, Pneumonia (other forms) 4, Poliomyelitis 3, Influenza 1, Syphilis 1, other deaths under one year 23, other deaths over one year 187, Stillbirths 15. Total 309.

URBAN—Cancer 35, Lethargic Encephalitis 30, Poliomyelitis 9, Tuberculosis 8, Pneumonia Lobar 4, Pneumonia (other forms) 3, Syphilis 2, Diphtheria 1, Influenza 1, Parotitis, acute 1, Sporotrichosis 1, other deaths under one year 14, other deaths over one year 157, Stillbirths 17. Total 283.

INDIANS—Tuberculosis 9, Influenza 1, other deaths under one year 9, other deaths over one year 4, Stillbirths 1. Total 24.

Disease	Manitoba Sept. 10-Oct. 7	Ontario Sept. 7-Oct. 4	Saskatchewan Sept. 7-Oct. 4	Minnesota Sept. 7-Oct. 4	North Dakota Sept. 7-Oct. 4
Anterior Poliomyelitis	79	34	18	79	2
Meningococcal Meningitis	1	26	1		
Chickenpox	71	252	15	71	
Diphtheria	11	11	5	11	7
Erysipelas	3	6	3	1	
Influenza	4	44	15	3	3
Encephalitis Epidemic	20		128	48	78
Measles	12	103	41	35	30
German Measles	2	34	22		
Mumps	51	169	54		
Lobar Pneumonia	3	27		31	11
Scarlet Fever	49	367	53	79	11
Septic Sore Throat	2	39			
Smallpox				1	
Trachoma			1		
Tuberculosis	20	185	40	84	55
Typhoid Fever	4	22	44	4	2
Paratyphoid Fever	1	2	83		
Undulant Fever		6	2		
Whooping Cough	2	417	23	238	65

Note: In looking over the records from the adjoining Provinces and States for the four-week period ending October 4th and 7th it is to be noted that the encephalitis epidemic has pretty well ceased excepting for "late reported" cases. A few cases of poliomyelitis are still being reported but these are mostly late ones. Ontario has twenty-six cases of meningococcal meningitis, also a fair amount of scarlet fever and septic sore throat.

Saskatchewan is having an epidemic of typhoid and para-typhoid fever—127 cases in the four-week period. These are mostly in the area around North Battleford and north of there. Regina has a few cases and there are odd scattered cases. We have had one case which came in from Saskatchewan. The four Manitoba cases are all in one family in the Municipality of DeSalaberry.